STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555375	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Post Acute	3232 E. Artesia Blvd. Long Beach, CA 90805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to notify the physician for one of three sampled residents (Resident 1) when Resident 1's renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) scheduled days were changed. As a result, Resident 1's scheduled dialysis days were changed without Resident 1's physician being made aware. This deficient practice placed Resident 1 at risk for worsening symptoms associated with end stage renal disease ([ESRD] irreversible kidney failure).Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including ESRD, and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 5/9/2026, the MDS indicated Resident 1 had moderate cognitive impairment (a phase of cognitive decline where memory loss and thinking difficulties become consistently noticeable to others and interfere with complex daily tasks). Resident 1 required substantial assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, showering/bathing, dressing, rolling left to right, sit to lying, lying to sitting on side of bed sitting to standing, transferring from chair/bed to chair, toileting transfer, and walking 10 feet. During a review of Resident 1's Physician Orders, dated 5/3/2026, the Physician Orders indicated Resident 1 was to receive dialysis at an outside facility every Monday, Wednesday, and Friday. During a review of Resident 1's Nursing Dialysis Communication Record, dated 6/1/2026 and timed at 5:41 p.m., the Nursing Dialysis Communication Record indicated Resident 1 was to have dialysis 6/2/2026 (Tuesday) at 1 p.m., instead of 6/3/2026 (Wednesday). During an interview on 6/11/2026 at 3:57 p.m., Licensed Vocational Nurse (LVN) 5 stated on 6/1/2026 she called the dialysis clinic to find out why Resident 1's dialysis date was changed from 6/3/2026 (Wednesday) to 6/2/2026 (Tuesday). She was told by the dialysis clinic that Resident 1 requested the change in her dialysis schedule because she wanted to attend her son's graduation on 6/3/2026 (Wednesday). LVN 5 stated she did not notify Resident 1's physician about the change in Resident 1's dialysis schedule or obtain an order from the physician because she did not know she needed to do so. During an interview on 6/12/2026 at 4:14 p.m., the Director of Nursing (DON) stated Resident 1 needed an order when her dialysis day was changed from 6/3/2026 (Wednesday) to 6/2/2026 (Tuesday) in order to coordinate care with her physician. The DON stated if it was not ordered by the physician, it should not have been done. During a review of facility's Policy and Procedure (P/P) titled Change in a Resident's Condition or Status dated 2001, the P/P indicated the nurse will notify the resident's physician or physician on call when there has been a need to alter the resident's medical treatment significantly, and specific instructions to notify the physician of changes in the resident's condition. During a review of facility's P/P titled Physician Services dated 2001, the P/P indicated the medical needs of each resident is supervised by a licensed physician which includes supervising the medical care of residents such as participating in the resident's (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment and care planning, and prescribing medications and therapy. The physician will determine relevance of any recommended interventions from other disciplines.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop a care plan that addressed the root cause (falling asleep) of Resident 1's previous falls on [DATE] and [DATE] for one of three sampled residents (Resident 1), who was assessed as a high fall risk. This failure resulted in Resident 1's continued falls on [DATE] and [DATE] after her drowsiness/falling asleep was not addressed following falls on [DATE] and again on [DATE], which possibly contributed to her death on [DATE], when approximately 48 minutes after falling asleep and falling from her bed, Resident 1 was found unresponsive and expired on [DATE] at 12:52 a.m.Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had a diagnosis of idiopathic peripheral autonomic neuropathy (a condition involving damage to the nerves that control involuntary bodily functions, such as heart rate, blood pressure, and digestion. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had moderate cognitive impairment (a phase of cognitive decline where memory loss and thinking difficulties become consistently noticeable to others and interfere with complex daily tasks). Resident 1 required substantial assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, showering/bathing, dressing, rolling left to right, sit to lying, lying to sitting on side of bed sitting to standing, transferring from chair/bed to chair, toileting transfer, and walking 10 feet. During a review of Resident 1's Fall Risk Observation/Assessment, dated [DATE], the Fall Risk Observation/Assessment indicated Resident 1 was a high risk for falls. During a review of Resident 1's At Risk for Falls Care Plan, dated [DATE], the Care Plan indicated Resident 1 was at high risk for falls due to diagnoses of neuropathy and generalized weakness. The goal of the Care Plan was to minimize Resident 1's risk for falls to the extent possible. The Care Plan's interventions included placing a star identifier on the outside of Resident 1's bedroom, on assistive devices, anticipate Resident 1's needs, educate/remind Resident 1 to call for assistance with all transfers, keep the call light and personal items within reach, supervise Resident 1 as much as possible, and to obtain a rehabilitation (aims to restore, keep, or improve the physical, mental, and cognitive abilities needed for daily life that were lost due to illness, injury, or surgery) consultation. During a review of Resident 1's SBAR ([situation, background, assessment, recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents) dated [DATE] and timed at 12:35 a.m., the SBAR indicated Resident 1 was found on her hands and knees. Resident 1 told staff she had been sleeping and rolled out of bed. During a review of Resident 1's Unwitnessed Fall Care Plan dated [DATE], the Care Plan indicated Resident 1 was at risk for recurring falls, with a goal for Resident 1 to comply with fall interventions, which included bilateral bed bolsters and bilateral floor mats. Continue review of Resident 1's Care Plan indicated the Care Plan did not address Resident 1 falling asleep prior to her rolling out of bed. During a review of the Rehab StatusˆPostˆFall Screen, dated [DATE], the Rehab Status-Post-Fall Screen indicated on [DATE] at 3:05 a.m., Resident 1 experienced an unwitnessed fall and reported she fell asleep while sitting in her wheelchair.During a review of Resident 1's Incident Report, dated [DATE] and timed at 3:05 a.m., the Incident Report indicated Resident 1 was found on the floor in front of her wheelchair and reported she fell asleep and fell forward, landing on her knees. During a review of Resident 1's Unwitnessed Fall Care Plan dated [DATE], the Care Plan indicated Resident 1 had an unwitnessed fall on [DATE]. The Care Plan's goal was to minimize the risk for additional falls to the extent possible. The Care Plan's interventions were to anticipate and meet Resident 1's needs, educate/remind Resident 1 to call for assistance, to keep the call light within reach, and to keep personal/frequently used items within reach. Continued review of Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's Care Plan indicated there was no identified trend of Resident 1 falling asleep prior or falls occurring on [DATE] and [DATE]. During a review of Resident 1's Nursing Progress Note, dated [DATE], the Nursing Progress Note indicated on [DATE] at 11:33 p.m., Resident 1 was found (in her room) on a floor mat on her left side, facing the window. Resident 1 reported while sitting on the side of her bed she fell asleep and fell (off the bed). The Nursing Progress Note indicated at 12:21 a.m. ([DATE]), Resident 1 was assessed unresponsive (a person is unconscious and fails to react to any external stimulation), CPR was initiated, 911 was called, and paramedics arrived at 12:36 a.m., and took over patient care. During a review of Resident 1's Nursing Progress Note, dated [DATE], the Nursing Progress Note indicated Paramedics pronounced Resident 1 deceased at 12:52 a.m. ([DATE]). During an interview on [DATE], at 9:08 a.m., RN 1 stated Certified Nursing Assistant (CNA) 1 reported to him ([DATE]) that Resident 1 was lying on the floor. Resident 1 reported she was sitting on the side/edge of her bed, she fell asleep and slipped out of bed. Resident 1 had a previous fall on [DATE] when she fell asleep while sitting in her wheelchair and fell from her wheelchair. RN 1 stated there were no interventions on Resident 1's Care Plan that addressed Resident 1's sleepiness and falls. During an interview on [DATE] at 2:21 p.m., the MDS Nurse (MDSN) stated Resident 1's At Risk for Falls Care Plan dated [DATE] indicated supervise as much as possible meant the resident was placed near the nursing station in a room that was more visible than other rooms. She also stated the phrase supervise as much as possible meant charge nurses and CNAs were informed to keep an eye on Resident 1 as much as possible. The MDS nurse could not explain how the intervention to supervise as much as possible was measurable and could be evaluated for effectiveness. During a interview on [DATE] at 3:57 p.m., Licensed Vocational Nurse (LVN) 5 stated Resident 1 fell three times ([DATE], [DATE] and [DATE]) after falling asleep. During an interview on [DATE] at 3:35 p.m., the Director of Nursing (DON) stated the root cause of Resident 1's falls on [DATE], [DATE], and [DATE] were due to Resident 1 falling asleep. This trend was not addressed in Resident 1's care plans or discussed with the Interdisciplinary Team (a group of people with different specialties who work together toward the same goal. Each person brings their own skills and perspective, and they share information so they can make better decisions as a team) due to an oversight and that addressing it might have prevented Resident 1 from falling on [DATE]. During a review of facility's Policy and Procedure (P/P) titled Care Plans, Comprehensive Person-Centered dated 1/2026, the P/P indicated the purpose of the policy was to include measurable objectives and timetables on the resident care plan to meet their physical, psychosocial, and functional needs for each resident. The care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessment of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change. During a review of facility's P/P titled Fall and Fall Risk, Managing dated 1/2026, the P/P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Risk factors included delirium, cognitive impairment, lower extremity weakness, medication side effects, functional impairments, heart failure, anemia, balance and gait disorders, pain.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility's staff failed to immediately initiate Cardiopulmonary Resuscitation ([CPR] an emergency procedure to restart a person's heart and breathing after one or both suddenly stop) to one of three sampled residents (Resident 1), when Registered Nurse (RN) 1 and Certified Nursing Assistant (CNA) 1, who were CPR certified (successfully completed a training course and received a credential that qualifies a person to perform CPR), found Resident 1 unresponsive (a person is unconscious and fails to react to any external stimulation), not breathing and without a pulse on [DATE] at 12:21 a.m. In addition, seven of eight staff who were CPR certified (Licensed Vocational Nurse [LVN] 1, LVN 3, LVN 4, LVN 5, Certified Nursing Assistant [CNA] 2, CNA 3, and CNA 4) did not initiate or assist in CPR after a code blue was called for Resident 1. The facility failed to implement its Policy and Procedure (P/P) titled Emergency Procedure-Cardiopulmonary Resuscitation and Basic Life Support ([BLS] a set of emergency medical procedures designed to sustain life by maintain breathing and circulation) that indicated to select and identify a CPR team for each shift in the case of an actual cardiac arrest and to the extent possible, designate a team leader on each shift who is responsible for coordinating and directing other team members during rescue efforts. Staff are trained to follow current American Heart Association (AHA) guidelines and recommendations for the resuscitation. As a result of these deficient practices, there was a delay in providing CPR to Resident 1. Resident 1 was pronounced dead on [DATE] at 12:52 a.m. On [DATE] at 5:02 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM), the Assistant Director of Nursing (ADON), and a Registered Nurse Consultant (RNC) due to the facility's failure to provide BLS to Resident 1, including immediate initiation of CPR, which potentially contributed to Resident 1's death. An IJ Removal Plan (IJRP, a plan to immediately correct the deficient practices) was immediately requested. On [DATE] the facility submitted an acceptable IJ Removal Plan ([IJRP] a plan to immediately correct the deficient practices). After onsite verification of the facility's IJRP implementation through observations interview, and record review the IJ was removed on [DATE] at 4:57 p.m., in the presence of the ADM and the DON. Non-compliance of F678 remained at the scope and severity of D no actual harm with potential for more than minimal harm that is not immediate Jeopardy. The IJRP included the following: 1. On [DATE], the Assistant Director of Nursing (ADON) conducted individualized one-on-one in-service training with RN 1, LVN 2, LVN 3, LVN 4, LVN 5, CNA 1, CNA 2, CNA 3, and CNA 4 regarding the [DATE] Code Blue event and the facility's Emergency Response/Cardiopulmonary Resuscitation policy. The individualized in-services were conducted either in person or by telephone, based on staff availability. For staff members who were unavailable to attend the in person in-service they received the in-service by telephone, a witness was present during the telephone in-service to verify that the education was conducted, the content was reviewed, and the staff member was given the opportunity to ask questions. Any resident found unresponsive and pulseless, who did not have a DNR order, CPR must be initiated immediately, Code Blue must be activated, 911 must be called immediately, and the crash cart must be retrieved without delay. The Code Status Binder located at each nurses' station and inside each crash cart, the binder contains current physician orders, Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) forms, and advance directive documentation. The ADON reviewed each staff member's individual responsibilities during a Code Blue. For staff members who receive the in-service via phone, they will undergo another refresher in-service onsite when they return to work. 2. On [DATE], the ADON reviewed and verified the BLS certification status for RN 1, (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LVN 2, LVN 3, LVN 4, LVN 5, CNA 1, CNA 2, CNA 3, and CNA 4. Each staff member was confirmed to have an active and current BLS certification card on file. 3. On [DATE], the ADON in collaboration with the Assistant Director of Staff Development (ADSD) conducted a review of all nursing staff CPR/BLS certification records to verify that each staff member had a current and active CPR/BLS certification on file. Any staff member identified without a current and active CPR/BLS certification was immediately removed from resident care assignments and was not permitted to provide direct resident care until current certification was obtained, submitted, reviewed, and verified by the ADON/designee or DSD/designee. 4. On [DATE], the Regional Director of Staff Development (RDSDS) in collaboration with the ADON conducted an audit of all current in-house residents to verify accurate code status. The audit included review of each resident's current POLST/advance directive documentation and medical record to ensure the resident's code status was accurate, clearly documented, and readily identifiable. 5. On [DATE], the ADON in collaboration with the RDSD provided in-service education to licensed nurses and CNAs regarding the designated CPR/Code Blue team, including each team member's assigned role during a Code Blue emergency. The CPR/Code Blue team would be identified for each shift and would be comprised of the RN Supervisor, the Station 1 Charge Nurse(s), the Station 4 Charge Nurse(s), and the CNAs assigned to Run #1 for Station 2 and Station 3. The RN Supervisor will serve as the Code Blue team leader and will be responsible for coordinating the emergency response, directing team members, documenting time of events, ensuring CPR is initiated immediately when indicated, Code Blue is activated, 911 is called, the crash cart is retrieved without delay, and the ADM/DON are notified of code blue before the end of the shift. In the event that a designated CPR/Code Blue team member is on a meal or rest break, the assigned break relief nurse or CNA covering that staff member's assignment will assume the CPR/Code Blue team role until the designated team member returns. The RN Supervisor will ensure coverage is identified before any CPR/Code Blue team member leaves the unit for break. Break coverage and/or alternate CPR/Code Blue team members will be reflected on the shift assignment sheet or break schedule to ensure there is no lapse in emergency response coverage. Regardless of assigned CPR/Code Blue team designation or break status, any CPR/BLS-certified staff member who finds a resident unresponsive and pulseless must immediately initiate CPR when indicated, activate Code Blue, ensure 911 is called, and request the crash cart without delay. The assigned CPR/Code Blue team members and break relief coverage will be clearly documented on each shift assignment sheet to ensure staff are aware of their roles and responsibilities prior to assuming resident care assignments. 6. On [DATE], the DON in collaboration with a CPR-certified instructor, initiated CPR/BLS skills check offs for nursing staff to validate competency and ensure staff can respond appropriately during a Code Blue emergency. The skills check offs included recognition of an unresponsive and pulseless resident, immediate initiation of CPR when indicated, activation of Code Blue, immediate 911 notification, crash cart retrieval, code status verification, role assignment, and use of clear communication during the emergency response. The CPR certified instructor conducted the Train the Trainor with the DON, ADON, Minimum Data Set (MDS) Coordinator, MDS Nurse Assistant, and Infection Prevention Nurse (IPN) and will continue until all licensed nurses and CNAs are trained. Systemic Changes and Education: 1. On [DATE], the facility initiated a systemic corrective action to schedule and conduct Mock Code Blue drills for nursing staff on all shifts. Mock Code Blue drills began on [DATE] during the 3:00 p.m. to 11:00 p.m. shift and included staff transitioning onto the 11:00 p.m. to 7:00 a.m. shift. On [DATE] and [DATE], Mock Code Blue drills were conducted on all three shifts. Mock Code Blue drills will continue on each shift through [DATE], then weekly on random shifts for three months, and monthly on random shifts thereafter. The DON/ADON will conduct a review for every code blue activation the following business day to evaluate success of mock drills. 2. For newly-hired licensed nurses and Certified Nursing Assistants as part of their orientation, staff will be trained regarding the facility's Emergency Procedure - Cardiopulmonary Resuscitation and Basic Life Support policy provided by the ADON. The Social Services Director/designee will conduct daily audits of all current (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in-house residents' physician orders, POLST and advance directives to ensure each resident's code status is accurate, current, clearly documented, and readily accessible in the Code Status binders, which will be located in each nursing station and inside each crash cart.Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including chronic obstructive pulmonary disease ([COPD] a chronic lung disease causing difficulty in breathing) heart failure, pulmonary hypertension ([HTN] when the blood vessels in your lungs have too much pressure, forcing the right side of your heart to work harder to pump blood through them), acute embolism (when a sudden blood clot travels through your bloodstream and gets stuck blocking blood flow in a vital area like your lung or brain) and thrombosis (when a blood clot that forms inside a blood vessel and gets stuck, blocking normal blood flow like a leg vein of heart artery) of the internal bilateral jugular vein (the two big veins on each side of your neck that carry blood from your brain back to your heart), and acute embolism and thrombosis of unspecified deep veins of left lower extremities. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had moderate cognitive impairment (a phase of cognitive decline where memory loss and thinking difficulties become consistently noticeable to others and interfere with complex daily tasks). Resident 1 required substantial assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, showering/bathing, dressing, rolling left to right, sit to lying, lying to sitting on side of bed sitting to standing, transferring from chair/bed to chair, toileting transfer, and walking 10 feet. During a review of Resident 1's Physician Orders for Life-Sustaining Treatment ([POLST] a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) dated [DATE], the POLST indicated if Resident 1 was in cardiopulmonary, CPR was required. During a review of Resident 1's Nursing Progress Note, dated [DATE] at 11:33 p.m., the Nursing Progress Note indicated on [DATE] at 11:33 p.m., CNA 5 notified RN 1 that Resident 1 was found (in her room) on the floor mat on her left side, facing the window. Resident 1 reported while sitting on the side of her bed she fell asleep and fell (off the bed). Resident 1 was unsure if she hit her head, but then later denied hitting her head and refused to be transferred to a General Acute Care Hospital (GACH) for further evaluation. During a review of Resident 1's Nursing Progress Note dated [DATE] and timed at 12:21 a.m., the Nursing Progress Note indicated Resident 1 was unresponsive, not responding to verbal or tactile stimuli (any physical inputs or mechanical energy [like touch, pressure, vibration, or texture] applied to the skin that activates the body's sensory receptors), CPR was initiated, 911 was called, paramedics arrived at 12:36 a.m. and took over Resident 1's care. During a review of Resident 1's Nursing Progress Note, dated [DATE] at 1:48 a.m., the Nursing Progress Note indicated Paramedics pronounced Resident 1 deceased at 12:52 a.m. During a review of the Fire Call History, dated [DATE], the Fire Call History indicated on [DATE] the facility called 911 at 12:20 a.m., paramedics were dispatched at 12:21 a.m., and arrived on scene at 12:31 p.m. During a review of Resident 1's Paramedic Run Sheet, dated [DATE], the Paramedic Run Sheet indicated Paramedics arrived at Resident 1's bedside at 12:36 a.m., and found Resident 1 lying supine (lying flat on your back with your face upward) in bed, pulseless and apneic (a state or condition where breathing completely stops), CPR was continued by paramedics. The Paramedic Run Sheet indicated Resident 1's time of death was 12:52 a.m. ([DATE]). During an interview on [DATE], at 9:08 a.m., RN 1 stated on [DATE] at 11:33 p.m., CNA 1 reported to him that Resident 1 was found on the floor. Resident 1 did not know if she hit her head and she refused to go to the GACH. Resident 1 was moved to a room closer to the nursing station, and CNA 1 was assigned to watch her. At approximately 12:21 a.m. ([DATE]), RN 1 stated he found Resident 1 was found unresponsive and without a pulse. RN 1 stated he left the room to call a code blue on the facility's intercom system at Nursing Station 1 (approximately 35 feet away from Resident 1's room), grabbed the crash cart inside a locked utility room (approximately 50 feet away from Resident 1's room), and took it to Resident 1's room, he then (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ran back to Nursing Station 1 and called 911. When he returned to Resident 1's room, he saw someone (unsure who) doing chest compressions and someone else (unsure who) using a bag-valve-mask ([BVM] a handheld manual breathing aid used to provide positive pressure when someone is not breathing on their own). He left the room a second time to call 911 because the paramedics were taking a long time. RN 1 stated CNA 1 was in the room when he assessed Resident 1 as unresponsive, not breathing and without a pulse, but he did not think to instruct CNA 1 to call code blue, get the crash cart or call 911, he was not sure why he did not ask for CNA 1's assistance, he should have. During an interview on [DATE] at 12:35 p.m., LVN 2 stated on [DATE] at approximately 12:20 a.m., a code blue was called to Resident 1's room, she ran to Resident 1's room and saw LVN 1 standing in the doorway, then leaving the room. LVN 3, LVN 4, LVN 5, CNA 2, CNA 3, and CNA 4 were in Resident 1's room not doing or saying anything. LVN 2 stated she checked Resident 1's pulse, began chest compressions and asked LVN 5 to get the BVM.During an interview on [DATE] at 10:21 a.m., CNA 1 stated on [DATE] sometime between 11:30 p.m. and 12 a.m., Resident 1 was transferred to a room closer to the nursing station because she had fallen and needed to be monitored, she was assigned as a sitter (a helper who stays in a resident's room to ensure their safety and comfort, especially if they are at risk for falls, wandering or harming themselves) to watch Resident 1. Initially Resident 1 was awake, alert, oriented, and asking for her belongings but approximately 25 minutes after arriving her new room, she (CNA 1) noticed Resident 1's eyes were closed, she tried to arouse her, but Resident 1 did not respond. RN 1 was walking by the room, she reported to him that Resident 1 would not wake up. CNA 1 stated RN 1 tried to arouse Resident 1, but Resident 1 did not respond, he then checked her pulse, left the room, and called a code blue using the facility's intercom system at Nursing Station 1. CNA 1 stated RN 1 did not tell her that Resident 1 had no pulse, and he did not ask her for assistance. CNA 1 stated she was CPR certified, and if Resident 1 had no pulse she or RN 1 should have started compressions while the other one went for help.During an interview on [DATE] at 12:08 p.m., LVN 2 stated she had not received training on the facility's CPR P/P or what to do during a code blue. She was not instructed by the facility regarding a designated team leader or a code team that would operate in an emergency where CPR was warranted. During an interview on [DATE] at 12:15 p.m., the ADON stated CNAs at the facility were CPR certified and were expected to participate in CPR. The ADON stated the facility did not have team leaders or a CPR team designated for each shift. The DON stated CPR codes were run following a chain of command; the RN, LVN, then the CNA. If he found a resident unresponsive, he would yell for help and delegate someone to check the resident's POLST, which was located in their POLST binder, call 911, and activate a code blue. He would stay with the resident, but he would not initiate CPR until the resident's code status was confirmed to ensure the resident's wishes were implemented. The ADON stated he was not familiar with the facility's CPR policies. During a review of facility's P/P titled Emergency Procedure-Cardiopulmonary Resuscitation and Basic Life Support dated 2001, the P/P indicated to select and identify a CPR team for each shift in the case of an actual cardiac arrest and to the extent possible, designate a team leader on each shift who is responsible for coordinating and directing other team members during rescue efforts. And staff are trained to follow the current AHA guidelines and recommendations for the resuscitation. During a review of the AHA Guidelines, dated 2025, the AHA Guidelines indicated for adult basic life support for healthcare professionals the algorithmic steps are:1. Verify scene safety2. Check for responsiveness3. Shout for help nearby4. Activate the emergency response system5. Send someone to get the AED/defibrillator6. Look for breathing and check a pulse simultaneously within 10 seconds\7. If there is no pulse start CPR by performing 30 compressions to 2-breath until an AED/defibrillator arrives8. Once AED arrives check for a shockable rhythm9. If not shockable resume CPR immediately for 2 minutes until prompted by the AED machine and continue until Advanced Life Support (ALS) professionals take over or the person starts to move.https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/algorithms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555375	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Post Acute	3232 E. Artesia Blvd. Long Beach, CA 90805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure crash carts (a mobile cart stocked with lifeˆsaving equipment that staff use during emergencies, such as when a patient stops breathing or their heart stops) located at multiple nursing stations were stocked per the Emergency Crash Cart Checklist, the crash carts were easily accessible to staff in the event of an emergent event, and the POLST ([Physician Orders for Life-Sustaining Treatment] a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) was easily identifiable. These deficient practices had the potential to delay emergency response, impede the timely initiation of Cardiopulmonary Resuscitation ([CPR] an emergency procedure to restart a person's heart and breathing after one or both suddenly stop), and negatively affect resident outcomes during a medical emergency.Findings: During a review of the facility's Emergency Crash Cart Checklist, the Emergency Crash Cart Checklist indicated a full tank of oxygen (O2), and sterile water. 1. During an observation on [DATE] at 9 a.m., Crash Cart 1 was observed near Nursing Station 1 inside a locked utility room, the locked utility room required a code for entry. Crash 1 was observed with an empty canister of O2. 2. During an observation on [DATE] at 9:16 a.m., Crash Cart 2 was observed near Nursing Station 2 inside a locked utility room, the locked utility room required a code for entry. Crash Cart 2 was observed with no labels on its drawers, making it difficult to identify and access those items difficult. 3. During an observation on [DATE] at 9:24 a.m., Crash Cart 3 was observed near Nursing Station 3 inside a locked utility room, the locked utility room required a code for entry. Crash Cart 3 was observed without sterile water. During an interview on [DATE] at 9:33 a.m., the Assistant Director of Nursing (ADON) stated it was the night shift Registered Nurse Supervisor's (RNS) responsibility to ensure all crash carts were restocked, supplies were available, and O2 tanks were replaced. The ADON stated storing crash carts in locked utility rooms that required a code to gain entry, Crash Carts with missing items, empty O2 tanks and/or drawers that were not labeled for easy identification/location of items inside the drawers, could waste time and delay emergency response, noting every second counts during a code blue (an announcement used in facilities when a resident is experiencing medical emergency) and that earlier CPR improves resident outcomes. During an interview on [DATE] at 11:36 a.m., and a concurrent observation of a POLST binder located at Nursing Station 1 that was amongst other miscellaneous charts, the POLST binder had no label and was not easily identifiable as the POLST binder. Licensed Vocational Nurse (LVN) 6 looked for the POLST binder and was unable to locate it. During an interview on [DATE] at 9:50 a.m., the DON stated the Crash Carts should be easily accessible at each Nursing Station instead of in a locked utility room. During review of the facility's undated P/P titled Emergency Cart Supplies and Equipment, the P/P indicated the emergency cart must be within easy access of health care workers, and the DON or designee must ensure the cart is stored within easy access, routinely checked for completeness, and that all equipment is in working order. The P/P indicated to ensure the oxygen tank is stocked up, and daily checks of the emergency cart for completeness, and immediate replacement of supplies after use.